PATIENT INFORMATION

Patient Name: _____ **Date**_____
Last, First MI (Preferred Name)

Gender: _____ **Family Status:**_____

Social Security #:_____**Date of Birth (M/D/Y):**_____

Phone (Home):_____ **(Work):**_____ Ext:_____**Other Phone #:** _____

Address: _____
Street Apartment #

_____
City State Zip Code

Preferred appointment times: ☐ Morning ☐ Afternoon ☐M ☐T ☐W ☐TH ☐F

HEALTH INFORMATION

Date of Last Dental Visit:_____ Reason for this visit: _____
Would you like to receive **FLUORIDE**? ☐ Yes ☐ No

Please check all that apply to you.

☐ AIDS	☐ Excessive Bleeding	☐ Kidney Disease	☐ Venereal Disease
☐ Allergies: _____	☐ Fainting	☐ Liver Disease	☐ Codeine Allergy
_____	☐ Glaucoma	☐ Mitral Valve Prolasp	☐ Penicillin Allergy
☐ Anemia	☐ Questionable Growths	☐ Nervous Disorders	☐ Sulpha Allergy
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Latex Allergy
☐ Artificial Joints	☐ Head Injuries	☐ **Pregnancy** _____	☐ Do you snore?
☐ Asthma	☐ Headaches	☐ Radiation Treatment	☐ Grind your teeth?
☐ Blood Disease	☐ Heart Disease	☐ Respiratory Problems	☐ OTHER:
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	_____
☐ Diabetes	☐ Hepatitis	☐ Sinus Problems	☐ **List Medications:**
☐ Dizziness	☐ High Blood Pressure	☐ Stomach Problems	_____
☐ Epilepsy	☐ High Cholesterol	☐ Stroke	_____

•Are any of your teeth sensitive to HOT, COLD OR PRESSURE? _____

• Are you interested in Whitening your teeth? ☐ Yes ☐ No

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient -friend ☐Another patient - relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice:_____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address and: _____

phone number _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address, & # _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in case at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party